Thornhill (HB 2052) **Act No. 1017**

New law requires that all claims under health and accident insurance policies and all enrollee claims for reimbursement under a health maintenance organization (HMO) subscriber agreement be paid within 30 days of submission of the claim to the insurer or HMO. Allows the insured or enrollee to sue the insurer or HMO for double the amount of benefits due if not paid within such 30 days. Exempts workers' compensation benefits from the provisions of new law.

New law deletes prior law relative to HMO claims. Further establishes new standards for payment of claims by health insurance issuers, including insurers and HMOs, as follows:

(1) Requires payment of an electronic claim within 25 days of furnishing a correctly completed uniform claim to the issuer. Defines a "uniform claim form" as a form prescribed by rule by the Dept. of Insurance (DOI).

(2) Requires payment of nonelectronic claims submitted by health care providers for covered benefits within 45 days or 60 days, depending upon the date of submission of a correctly completed uniform claim form. Further requires payment of claims due an insured or not otherwise payable to the provider within 30 days of such submission.

(3) Requires health insurance issuers to have appropriate handling procedures approved by DOI for the acceptance of both electronic and nonelectronic claims, including a process for documenting the date of their receipt and reviewing them for accuracy and acceptability within a reasonable period of time.

(4) Requires that health insurance issuers pay a late payment adjustment of 1% of the amount due to any claimant not paid within the time frames specified above by new law. Also provides that for any period of more than 25 days following such time frames, an additional late payment adjustment of 1% of the unpaid balance due shall be paid for each month or partial month that the claim remains unpaid.

(5) Allows health insurance issuers to use a standard 30-day payment standard for compliance with new law by providing written notice to the commissioner of insurance.

(6) Provides that issuers which limit the time that a provider has to submit a claim shall be limited to the same period of time following its payment to review or audit the claim.

(7) Provides for standards for coordination of benefits requirements by health insurance issuers. Further authorizes the commissioner of insurance to adopt regulations on the order of benefits payments when a person is covered by two or more health plans.

(8) Authorizes the commissioner, after notice and hearing, to address violations of new law by: issuing cease and desist orders, imposing fines, or suspending or revoking a health insurance issuer's certificate of authority. Also provides for penalties for violation of cease and desist orders. Provides that hearings are subject to the provisions of Title 49, relative to adjudicatory hearings within the Division of Administrative Law.

(9) Requires that notice of any intentional violation of new law or

violation of a cease and desist order issued pursuant to new law by the State Employees Group Benefits Program be submitted to the governor and the chairmen of the House Appropriations Committee and the Senate Finance Committee.

(10) Authorizes the commissioner to adopt regulations necessary to implement new law.

New law provides that it shall not apply to the State Employees Group Benefits Program.

Effective upon signature of the governor or lapse of time for gubernatorial action.

(Amends R.S. 22:2027(F); Adds R.S. 22:250.31-250.37; Repeals R.S. 22:657(G))